Indiana Division of Disability and Rehabilitative Services

INCIDENT INITIAL REPORT - Confidential

For Use in Reporting Circumstances in 460 IAC 6-9-5, 431 IAC 1.1-3-1 (b) and/or DDRS Policy and Procedures

REV 07-01-2008

SECTION I - CONSUMER INFORMATION (Subject #1)

SSN: _____ LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DOB: _____ COUNTY: _____ GENDER: _____

PRIMARY FUNDING SOURCE:

☐ AFC ☐ DD WVR ☐ SDC/SOF ☐ SUPP SRV WVR

☐ AUTISM WVR ☐ LP-ICF/MR ☐ SGL ☐ TITLE XX

☐ CFC ☐ NURSING HOME ☐ SLI RESIDENTIAL

INDICATE WHICH OF THE FOLLOWING AGENCIES AND INDIVIDUALS HAVE BEEN INFORMED:

RES. PROVIDER? ☐ YES ☐ N/A

HAB/VOC PROVIDER? ☐ YES ☐ N/A

OTHER PROVIDER? ☐ YES ☐ N/A

LEGAL GUARDIAN? ☐ YES ☐ N/A NAME DATE

BDDS SC? ☐ YES NAME DATE

CASE MANAGER? ☐ YES ☐ N/A NAME DATE

QMRP? ☐ YES ☐ N/A NAME DATE

APS/CPS? ☐ YES ☐ N/A NAME DATE

COUNTY PHONE METHOD

CORONER? ☐ YES ☐ N/A NAME DATE

POLICE? ☐ YES ☐ N/A DATE

SUPERVISORY PROVIDER INFORMATION

RESPONSIBLE SUPERVISORY PROVIDER: _____

INDIVIDUAL SUPERVISING AT TIME OF INCIDENT: _____

SECTION II - REPORTING PERSON and REPORTING AGENCY

LAST NAME: _____ FIRST NAME: _____ POSITION: _____ PHONE: _____ EXTENSION: _____

DATE REPORT SUBMITTED: _____ REPORTING AGENCY: _____ E-MAIL ADDRESS: _____

SECTION III - INCIDENT INFORMATION

INCIDENT **DATE** **TIME**

WHERE OCCURRED:

☐ AFC ☐ COMMUNITY HAB ☐ COMMUNITY JOB ☐ FAC. HAB. (ADC, ADL) ☐ HOME, AL ☐ HOME, FAMILY

☐ HOME, OWN ☐ HOSPITAL ☐ LP-ICF/MR ☐ NF ☐ SCHOOL ☐ SDC/SOF ☐ SGL ☐ WORKSHOP

☐ OTHER (Explain) _____

INCIDENT INITIAL REPORT(STANDARD) - Confidential

As Reported in Section 1 - Consumer information (Subject #1) - Confidential

Consumer Name:

Incident Date:

SSN:

Incident Time:

NARRATIVE: DETAILS - STANDARD

Describe the injury, condition or circumstance of the incident and the activities taking place immediately prior to the incident. Identify all participants and their involvement in the incident. Please be comprehensive but concise in explaining who, when, where, why, how and what was heard and/or observed.

Plan to Resolve (Immediate and Long Term).

INCIDENT INITIAL REPORT(DEATH) - Confidential

Is this incident regarding the death of this consumer? ☐YES ☐NO

As Reported in Section 1 - Consumer Information (Subject #1)

Name: _____ **Incident Date:** _____

SSN: **Incident Time:**

NARRATIVE: DETAILS - DEATH

Please include the following DEATH information:

1. Date of Death: **Time of Death:**

2. Place of Death:

☐AFC ☐DAY SERVICES / ADC ☐JAIL / PRISON ☐SDC / SOF

☐HOME, OTHER(FAMILY, FRIEND, ETC.) ☐LP ICF / MR ☐SGL / GROUP HOME

☐HOME, OWN(HOUSE, APT, ETC.) ☐NURSING FACILITY ☐SHELTER WORKSHOP

☐HOSPITAL ☐SCHOOL ☐WORK SETTING

☐OTHER SETTING(EXPLAIN / DESCRIBE)

3. What was the setting if in NF less than 90 days:

4. Circumstances immediately preceding the death, IF KNOWN:

5. Circumstances immediately following the death or discovery of the death, IF KNOWN:

6. Describe all life-saving measures, IF ANY WERE APPLICABLE, that were attempted at the time of death (i.e., CPR administered, 911 called, transported to hospital, etc.), IF KNOWN:

7. If no life-saving measures were taken, please explain why not (i.e., was there a no-code status, do not resuscitate (DNR) order, etc.), IF KNOWN:

8. Was the individual admitted into a nursing facility within 30 days of the date of death? ☐YES ☐NO

9. Was the individual discharged from a nursing facility within 30 days of the date of death? ☐YES ☐NO

10. Was the death of the individual expected? ☐YES ☐NO

11. Was there a DNR status? ☐YES ☐NO ☐NOT KNOWN

12. What is the preliminary cause of death?

13. Description of the event(s) surrounding this death is as follows:

INCIDENT INITIAL REPORT(PRN) - Confidential

Is this incident regarding a PRN administered to this consumer? ☐ YES ☐ NO

As Reported in Section 1 - Consumer Information (Subject #1)

Name: _____ **Incident Date:** _____

SSN: _____ **Incident Time:** _____

NARRATIVE: DETAILS - PRN

Please include the following PRN information:

1. Length of time the target behavior lasted:

2. Description of what precipitated the targeted behavior

3. Description of what efforts and/or activities were used and/or attempted to stop the behavior prior to the use of the PRN. For PRN's used before medical / dental procedures, description of the desensitization plan that is in place. Please Note: Even when a PRN has been approved by the guardian, physician, Human Rights Committee, IDT, etc., and/or is in the individual's BSP, this information is still mandatory to process this incident report.

4. State the criteria for the use of a PRN

5. PRN protocol (notification process, approval process, name and title of staff approving what medication and dosage)

6. Date / time of prior PRN